

**Montana WIC Program  
Benefit Void/Reissue Form**



Participant Name: \_\_\_\_\_

Participant ID#: \_\_\_\_\_

Clinic Name/Number: \_\_\_\_\_

Date of Void/Reissue: \_\_\_\_\_

Benefits to be voided:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Benefits that were reissued:

LDTU of benefit(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of cans of formula and type of formula returned: \_\_\_\_\_

Was any cereal or juice returned?   Y   or   N   If yes, how much? \_\_\_\_\_

Reason for void/reissue: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INSTRUCTIONS:** Complete this form with every void/reissue involving a USED formula food package change. Place one copy in the participant's folder and send the original to the State WIC Office, PO BOX 202951, Helena, MT 59620.

WIC Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_